

South Carolina Maternal Health Innovation Collaborative

Maternal Health Task Force Quarterly Meeting

Tuesday, March 4, 2025
10 am to 2 pm
Microsoft Teams



SCMHIC LEADERSHIP TEAM

South Carolina Department of Public Health (SCDPH)



KRISTEN SHEALY, MSPH

Principal Investigator



NICHOLAS RESCINITI, PhD, MPH, CPH

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Core Implementation and Evaluation Partner:
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Institute for Families in Society



ANA LÓPEZ – DE FEDE, PhD

Co-Principal Investigator
Distinguished Research
Professor Emerita



Agenda

Presentations

SC Maternal Mortality Review Committee Overview & Update

Current Statewide Maternal Health Initiatives: Opportunities for Alignment

Panel Discussion

Community Birth Workers in Clinical Settings

MHI Supported Projects

Lunch Break

Breakout Sessions

Workgroup Meetings

Report Out

Next Steps/Adjourn



Housekeeping

- The Chatham House Rule

"When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed."

- Share the information, but not who said it
- Keep names and affiliations private
- Encourages open and honest discussion



Icebreaker

What's the first thing
you're excited to do in
warmer weather?



SC Maternal Mortality & Morbidity Review Committee

2025 Legislative Brief Overview





Maternal Morbidity and Mortality Review Committee Update

Nicholas Resciniti, PhD
Kimberly Jenkins, BSN, RN

What is the South Carolina Maternal Morbidity and Mortality Review Committee (SCMMMRC)



- Legislatively mandated (2016 44-1-310).
- Statewide and multidisciplinary membership.
- Scope: deaths that occur during pregnancy or within 365 days.
- Goals: Identify the number of pregnancy-related deaths, identify trends and make actionable recommendations for prevention.
- Vision: Eliminate preventable pregnancy-related deaths, reduce maternal morbidities and improve population health for women of reproductive age in South Carolina.
- Reviewing Cohort 2022.
- Annual legislative brief published every March.
- Fall 2024 DPH was awarded a 5-year cooperative agreement by the CDC.

Pregnancy-associated death:

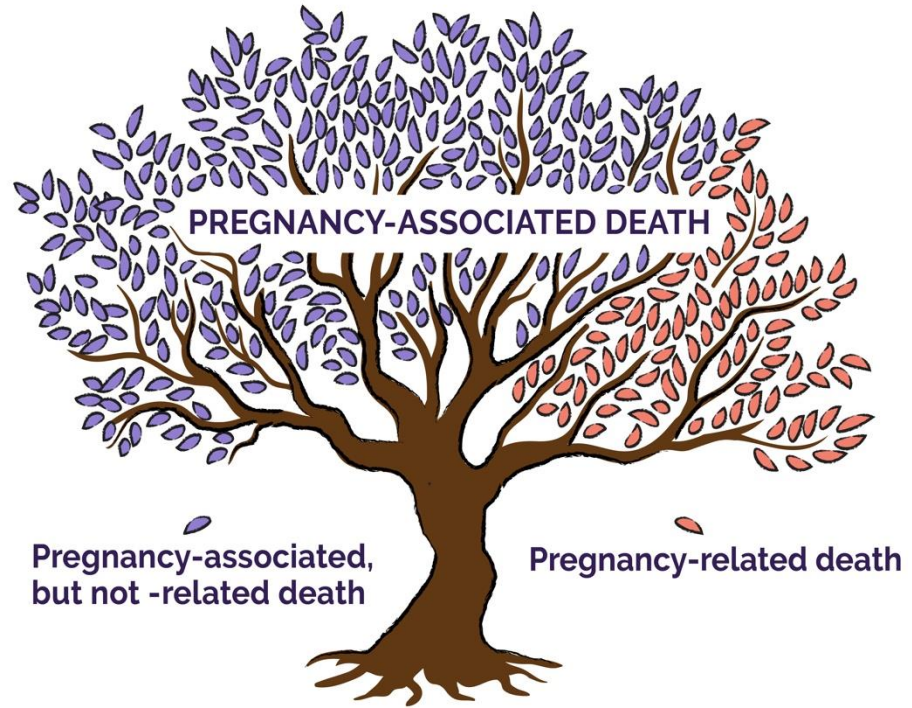
- A death during or within one year of pregnancy irrespective of cause.

Pregnancy-related death:

- A death while pregnant or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.

Pregnancy-associated, but not-related death:

- A death during or within one year of the end of pregnancy from a cause that is not related to pregnancy.

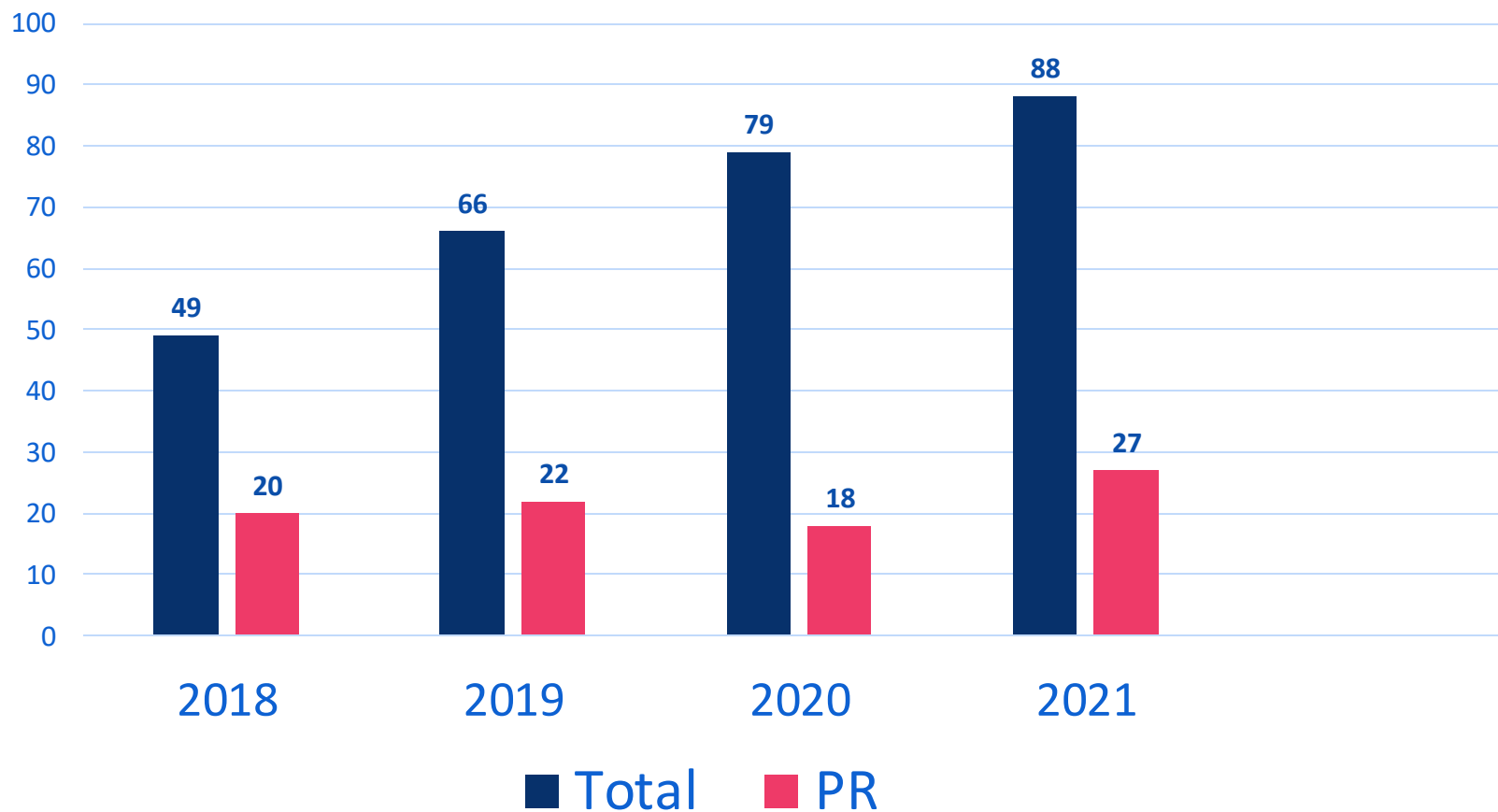


To determine whether a pregnancy-associated death is related to pregnancy it can be helpful to ask the following question:

If she had not been pregnant, would she have died?



Pregnancy-related deaths vs total deaths reviewed by the SCMMMRC



SCMMMRC Addresses Six Key Questions for Each Pregnancy- Related Death



1. Was the death pregnancy-related?
2. What was the cause of death?
3. Was the death preventable?
4. What are the critical contributing factors?
5. What are the recommendations and actions that address those contributing factors?
6. What is the anticipated impact of those actions if implemented?

Review: Pregnancy-Related Determination

MMRIA

REVIEW DATE

RECORD ID #

Month/Day/Year

PREGNANCY-RELATEDNESS: SELECT ONE

☐ PREGNANCY-RELATED
A death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy

☐ PREGNANCY-ASSOCIATED, BUT NOT-RELATED
A death during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy

☐ PREGNANCY-ASSOCIATED BUT UNABLE TO DETERMINE PREGNANCY-RELATEDNESS

ESTIMATE THE DEGREE OF RELEVANT INFORMATION (RECORDS) AVAILABLE FOR THIS CASE:

These fields are for internal jurisdiction use in order to evaluate opportunities to gain better access to information for reviews.

☐ COMPLETE
All records necessary for adequate review of the case were available

☐ SOMEWHAT COMPLETE
Major gaps (i.e., information that would have been crucial to the review of the case)

☐ MOSTLY COMPLETE
Minor gaps (i.e., information that would have been beneficial but was not essential to the review of the case)

☐ NOT COMPLETE
Minimal records available for review (i.e., death certificate and no additional records)

DOES THE COMMITTEE AGREE WITH THE UNDERLYING¹ CAUSE OF DEATH LISTED ON DEATH CERTIFICATE?

The underlying cause of death determination as documented by a multidisciplinary MMRC may be different from the underlying cause of death used by pathologists in the course of death certification documented in the Vital Statistics system.

☐ YES
☐ NO

PREGNANCY-RELATEDNESS: SELECT ONE

- ☐ **PREGNANCY-RELATED**
A death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy
- ☐ **PREGNANCY-ASSOCIATED, BUT NOT-RELATED**
A death during pregnancy or within one year of the end of pregnancy from a cause that is not related to pregnancy
- ☐ **PREGNANCY-ASSOCIATED BUT UNABLE TO DETERMINE PREGNANCY-RELATEDNESS**

Pregnancy-related death:

A death during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy

If she had not been pregnant, would she have died?

APPENDIX C. CONSENSUS PREGNANCY-RELATED CRITERIA FOR SUICIDE AND UNINTENTIONAL OVERDOSES^{9, 10}

Present Y/N	Consensus pregnancy-related criteria for suicide and unintentional overdoses	Examples
	Pregnancy Complication	
▼	Increased pain directly attributable to pregnancy or postpartum events leading to self-harm or drug use that are implicated in suicide or unintentional drug-related death. <i>[consensus during pregnancy]</i>	Back pain, pelvic pain, kidney stones, cesarean incision, or perineal tear pain
▼	Traumatic event in pregnancy or postpartum (diagnosis of fetal anomaly, stillbirth, preterm delivery, neonatal or infant death, traumatic delivery experience, removal of children from custody) with a temporal relationship between the event leading to self-harm or increased drug use and subsequent death. <i>[consensus in all time periods]</i>	Stillbirth, preterm delivery, diagnosis of fetal anomaly, traumatic delivery experience, relationship destabilization due to pregnancy, removal of child(ren) from custody
▼	Pregnancy-related complication likely exacerbated by drug use leading to subsequent death. <i>[consensus in pregnancy – only time period considered]</i>	Placental abruption or preeclampsia in setting of drug use
	Chain of Events Initiated by Pregnancy	
▼	Cessation or attempted taper of medications for pregnancy-related concerns (neonatal/fetal exposure risk, fear of child protective service involvement) leading to maternal destabilization or drug use and subsequent death. Neonatal or fetal risk - <i>[consensus in all time periods]</i> . Child Protective Service involvement - <i>[consensus during pregnancy]</i>	Substance use pharmacotherapy (methadone or buprenorphine), psychiatric medications, pain medications
▼	Inability to access inpatient or outpatient addiction or mental health treatment due to pregnancy. <i>[consensus during and within 6 months of pregnancy]</i>	Health care professionals uncomfortable with treating pregnant women, facilities not available that accept pregnant women
▼	Perinatal psychiatric conditions resulting in maternal destabilization or drug use and subsequent death. <i>[consensus during and within 6 months of pregnancy]</i>	Depression diagnosed in pregnancy or postpartum resulting in suicide
▼	Recovery/stabilization of substance use disorder achieved during pregnancy or postpartum with clear statement in records that pregnancy was motivating factor with subsequent relapse and subsequent death. <i>[no consensus at any time period]</i>	Relapse leading to overdose due to decreased tolerance or polysubstance use
	Aggravation of Underlying Condition by Pregnancy	
▼	Worsening of underlying depression, anxiety or other psychiatric condition in pregnancy or postpartum period with documentation that mental illness led to drug use or self-harm and subsequent death. <i>[consensus during and within 6 months of pregnancy]</i>	Pre-existing depression exacerbated in the postpartum period leading to suicide
▼	Exacerbation, under-treatment or delayed treatment of pre-existing condition in pregnancy or postpartum leading to use of prescribed or illicit drugs resulting in death, or suicide. <i>[consensus during and within 6 months of pregnancy]</i>	Undertreatment of chronic pain leading to misuse of medications or use of illicit drugs, resulting in death
▼	Medical conditions secondary to drug use in setting of pregnancy or postpartum that may be attributable to pregnancy-related physiology and increased risk of complications leading to death. <i>[no consensus at any time period]</i>	Stroke or cardiovascular arrest due to stimulant use

⁹ Smid MC et al, 2023. Consensus pregnancy-related criteria for suicide and unintentional overdoses using a Delphi process. Arch Womens Ment Health.

¹⁰ The italicized text in brackets specify where the Delphi exercise with representatives from 48 MMRCs and eight experts in maternal mortality, substance use disorder, and maternal mental health reached consensus on the criterion. Lack of Delphi consensus as shown in brackets should not override committee consensus on a specific case. If "Yes" is chosen by the committee for at least one of the boxes under any of the three categories then that would constitute a pregnancy-related death.

Review: Cause of Death (PMSS-MM codes)

MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM v24 1

COMMITTEE DETERMINATION OF CAUSE(S) OF DEATH

IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING¹ CAUSE OF DEATH
Refer to Appendix A for PMSS-MM cause of death list.

If a death is pregnancy-associated, not related then an underlying cause of death entry is not necessary. Use optional box below.

TYPE	OPTIONAL: CAUSE (DESCRIPTIVE)
UNDERLYING ^{1,2}	
CONTRIBUTING ^{2,3}	
IMMEDIATE ²	
OTHER SIGNIFICANT ⁴	

COMMITTEE DETERMINATIONS ON CIRCUMSTANCES SURROUNDING DEATH⁴

DID OBESITY CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

DID DISCRIMINATION⁵ CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

DID MENTAL HEALTH CONDITIONS OTHER THAN SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

DID SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

MANNER OF DEATH

WAS THIS DEATH A SUICIDE? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

WAS THIS DEATH A HOMICIDE? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

IF ACCIDENTAL DEATH, HOMICIDE, OR SUICIDE, LIST THE MEANS OF FATAL INJURY

☐ FIREARM	☐ FALL	☐ INTENTIONAL NEGLIGENCE
☐ SHARP INSTRUMENT	☐ PUNCHING/KICKING/BEATING	☐ OTHER, SPECIFY:
☐ BLUNT INSTRUMENT	☐ EXPLOSIVE	
☐ POISONING/OVERDOSE	☐ DROWNING	
☐ HANGING/STRANGULATION/SUFFOCATION	☐ FIRE OR BURNS	☐ UNKNOWN
	☐ MOTOR VEHICLE	☐ NOT APPLICABLE

IF HOMICIDE, WHAT WAS THE RELATIONSHIP OF THE PERPETRATOR TO THE DECEDENT?

☐ NO RELATIONSHIP	☐ OTHER	☐ UNKNOWN
☐ PARTNER	☐ ACQUAINTANCE	☐ NOT APPLICABLE
☐ EX-PARTNER	☐ OTHER, SPECIFY:	
☐ OTHER RELATIVE		

COMMITTEE DETERMINATION OF CAUSE(S) OF DEATH

IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING¹ CAUSE OF DEATH
Refer to Appendix A for PMSS-MM cause of death list.

If a death is pregnancy-associated, not related then an underlying cause of death entry is not necessary. Use optional box below.

*Underlying cause refers to the disease or injury that **initiated** the chain of events leading to death or the circumstances of the accident or violence which produced the fatal injury.*

PMSS-MM Codes for Reference



MMRIA		MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM v24	5
APPENDIX A. PMSS-MM CODES: IF PREGNANCY-RELATED, ² COMMITTEE DETERMINATION OF UNDERLYING ¹ CAUSE OF DEATH			
Hemorrhage (Excludes Aneurysms or CVA) 10.1 - Hemorrhage – Uterine Rupture 10.2 - Placental Abruptio 10.3 - Placenta Previa 10.4 - Ruptured Ectopic Pregnancy 10.5 - Hemorrhage – Uterine Atony/Postpartum Hemorrhage 10.6 - Placenta Accreta/Increta/Percreta 10.7 - Hemorrhage due to Retained Placenta 10.10 - Hemorrhage – Laceration/Intra-Abdominal Bleeding 10.9 - Other Hemorrhage/NOS		Hematologic 82.1 - Sickle Cell Anemia 82.9 - Other Hematologic Conditions including Thrombophilias/TTP/HUS/NOS Collagen Vascular/Autoimmune Diseases 83.1 - Systemic Lupus Erythematosus (SLE) 83.9 - Other Collagen Vascular Diseases/NOS Conditions Unique to Pregnancy 85.1 - Conditions Unique to Pregnancy (e.g., Gestational Diabetes, Hyperemesis, Liver Disease of Pregnancy)	
Infection 20.1 - Postpartum Genital Tract (e.g., of the Uterus/ Pelvis/Perineum/Necrotizing Fasciitis) 20.2 - Sepsis/Septic Shock 20.4 - Chorioamnionitis/Antepartum Infection 20.6 - Urinary Tract Infection 20.7 - Influenza 20.8 - COVID-19 20.10 - Pneumonia 20.11 - Other Non-Pelvic Infection (e.g., TB, Meningitis, HIV) 20.9 - Other Infection/NOS		Neurologic/Neurovascular Conditions (Excluding CVA) 92.1 - Epilepsy/Seizure Disorder 92.9 - Other Neurologic Diseases/NOS Renal Disease 93.1 - Chronic Renal Failure/End-Stage Renal Disease (ESRD) 93.9 - Other Renal Disease/NOS Cerebrovascular Accident (CVA) not Secondary to HDP 95.1 - Cerebrovascular Accident (Hemorrhage/ Thrombosis/Aneurysm/Malformation) not Secondary to Hypertensive Disorders of Pregnancy	
Embolism (Excludes Cerebrovascular) 30.1 - Embolism – Thrombotic 30.9 - Other Embolism (Excludes Amniotic Fluid Embolism)/NOS		Injury 88.1 - Intentional (Homicide) 88.2 - Unintentional 88.9 - Unknown Intent/NOS Cancer 89.1 - Gestational Trophoblastic Disease (GTD) 89.3 - Malignant Melanoma 89.9 - Other Malignancies/NOS	
Amniotic Fluid Embolism 31.1 - Amniotic Fluid Embolism		Other Cardiovascular Conditions (excluding cardiomyopathy, HDP, and CVA) 90.1 - Coronary Artery Disease/Myocardial Infarction (MI)/Atherosclerotic Cardiovascular Disease 90.2 - Pulmonary Hypertension 90.3 - Valvular Heart Disease Congenital and Acquired 90.4 - Vascular Aneurysm/Dissection (Non-Cerebral) 90.5 - Hypertensive Cardiovascular Disease 90.6 - Marfan Syndrome 90.7 - Conduction Defects/Arrhythmias 90.8 - Vascular Malformations Outside Head and Coronary Arteries 90.9 - Other Cardiovascular/NOS, including CHF, Cardiomegaly, Cardiac Hypertrophy, Cardiac Fibrosis, Non-Acute Myocarditis	
Hypertensive Disorders of Pregnancy (HDP) 40.1 - Preeclampsia 50.1 - Eclampsia 60.1 - Chronic Hypertension with Superimposed Preeclampsia		Gastrointestinal Disorders 97.1 - Crohn's Disease/Ulcerative Colitis 97.2 - Liver Disease/Failure/Transplant 97.9 - Other Gastrointestinal Diseases/NOS Mental Health Conditions 100.1 - Depressive Disorder 100.2 - Anxiety Disorder (including Post-Traumatic Stress Disorder) 100.3 - Bipolar Disorder 100.4 - Psychotic Disorder 100.5 - Substance Use Disorder 100.9 - Other Psychiatric Conditions/NOS	
Anesthesia Complications 70.1 - Anesthesia Complications		Unknown COD 999.1 - Unknown COD	
Cardiomyopathy 80.1 - Postpartum/Peripartum Cardiomyopathy 80.2 - Hypertrophic Cardiomyopathy 80.9 - Other Cardiomyopathy/NOS		Pulmonary Conditions (Excludes ARDS-Adult Respiratory Distress Syndrome) 91.1 - Chronic Lung Disease 91.2 - Cystic Fibrosis 91.3 - Asthma 91.9 - Other Pulmonary Disease/NOS	

Review: Committee Determinations on Circumstances Surrounding Death



MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM v24		1
COMMITTEE DETERMINATION OF CAUSE(S) OF DEATH		
IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING¹ CAUSE OF DEATH Refer to Appendix A for PMSS-MM cause of death list.		
If a death is pregnancy-associated, not related then an underlying cause of death entry is not necessary. Use optional box below.		
TYPE	OPTIONAL: CAUSE (DESCRIPTIVE)	
UNDERLYING ^{1,2}		
CONTRIBUTING ^{2,3}		
IMMEDIATE ²		
OTHER SIGNIFICANT ⁴		
COMMITTEE DETERMINATIONS ON CIRCUMSTANCES SURROUNDING DEATH⁴		
DID OBESITY CONTRIBUTE TO THE DEATH?	☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN	
DID DISCRIMINATION ⁵ CONTRIBUTE TO THE DEATH?	☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN	
DID MENTAL HEALTH CONDITIONS OTHER THAN SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH?	☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN	
DID SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH?	☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN	
MANNER OF DEATH		
WAS THIS DEATH A SUICIDE?	☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN	
WAS THIS DEATH A HOMICIDE?	☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN	
IF ACCIDENTAL DEATH, HOMICIDE, OR SUICIDE, LIST THE MEANS OF FATAL INJURY	☐ FIREARM ☐ SHARP INSTRUMENT ☐ BLUNT INSTRUMENT ☐ POISONING/OVERDOSE ☐ HANGING/ STRANGULATION/ SUFFOCATION	☐ FALL ☐ PUNCHING/ KICKING/BEATING ☐ EXPLOSIVE ☐ DROWNING ☐ FIRE OR BURNS ☐ MOTOR VEHICLE ☐ INTENTIONAL NEGLECT OTHER, SPECIFY:
IF HOMICIDE, WHAT WAS THE RELATIONSHIP OF THE PERPETRATOR TO THE DECEDENT?	☐ NO RELATIONSHIP ☐ PARTNER ☐ EX-PARTNER ☐ OTHER RELATIVE	☐ OTHER ☐ ACQUAINTANCE ☐ OTHER, SPECIFY: ☐ UNKNOWN ☐ NOT APPLICABLE

The checkboxes refer to the woman's own experience, not the broader context surrounding her death.

COMMITTEE DETERMINATIONS ON CIRCUMSTANCES SURROUNDING DEATH⁴			
DID OBESITY CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO ☐ UNKNOWN
DID DISCRIMINATION ⁵ CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO ☐ UNKNOWN
DID MENTAL HEALTH CONDITIONS OTHER THAN SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO ☐ UNKNOWN
DID SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH?	☐ YES	☐ PROBABLY	☐ NO ☐ UNKNOWN
MANNER OF DEATH			
WAS THIS DEATH A SUICIDE?	☐ YES	☐ PROBABLY	☐ NO ☐ UNKNOWN
WAS THIS DEATH A HOMICIDE?	☐ YES	☐ PROBABLY	☐ NO ☐ UNKNOWN
IF ACCIDENTAL DEATH, HOMICIDE, OR SUICIDE, LIST THE MEANS OF FATAL INJURY	☐ FIREARM ☐ SHARP INSTRUMENT ☐ BLUNT INSTRUMENT ☐ POISONING/OVERDOSE ☐ HANGING/ STRANGULATION/ SUFFOCATION	☐ FALL ☐ PUNCHING/ KICKING/BEATING ☐ EXPLOSIVE ☐ DROWNING ☐ FIRE OR BURNS ☐ MOTOR VEHICLE	☐ INTENTIONAL NEGLECT OTHER, SPECIFY: ☐ UNKNOWN ☐ NOT APPLICABLE
IF HOMICIDE, WHAT WAS THE RELATIONSHIP OF THE PERPETRATOR TO THE DECEDENT?	☐ NO RELATIONSHIP ☐ PARTNER ☐ EX-PARTNER ☐ OTHER RELATIVE	☐ OTHER ☐ ACQUAINTANCE ☐ OTHER, SPECIFY: ☐ UNKNOWN ☐ NOT APPLICABLE	

Review: Committee Determination on Discrimination

MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM v24		1
COMMITTEE DETERMINATION OF CAUSE(S) OF DEATH		
IF PREGNANCY-RELATED, COMMITTEE DETERMINATION OF UNDERLYING ¹ CAUSE OF DEATH Refer to Appendix A for PMSS-MM cause of death list.		
If a death is pregnancy-associated, not related then an underlying cause of death entry is not necessary. Use optional box below.		
TYPE	OPTIONAL: CAUSE (DESCRIPTIVE)	
UNDERLYING ^{1,2}		
CONTRIBUTING ^{2,3}		
IMMEDIATE ²		
OTHER SIGNIFICANT ⁴		
COMMITTEE DETERMINATIONS ON CIRCUMSTANCES SURROUNDING DEATH⁴		
DID OBESITY CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN		
DID DISCRIMINATION ⁵ CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN		
DID MENTAL HEALTH CONDITIONS OTHER THAN SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN		
DID SUBSTANCE USE DISORDER CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN		
MANNER OF DEATH		
WAS THIS DEATH A SUICIDE? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN		
WAS THIS DEATH A HOMICIDE? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN		
IF ACCIDENTAL DEATH, HOMICIDE, OR SUICIDE, LIST THE MEANS OF FATAL INJURY	☐ FIREARM	☐ FALL
	☐ SHARP INSTRUMENT	☐ PUNCHING/ KICKING/BEATING
	☐ BLUNT INSTRUMENT	☐ EXPLOSIVE
	☐ POISONING/OVERDOSE	☐ DROWNING
	☐ HANGING/ STRANGULATION/ SUFFOCATION	☐ FIRE OR BURNS
	☐ INTENTIONAL NEGLIGENCE	☐ OTHER, SPECIFY:
	☐ MOTOR VEHICLE	☐ UNKNOWN
		☐ NOT APPLICABLE
IF HOMICIDE, WHAT WAS THE RELATIONSHIP OF THE PERPETRATOR TO THE DECEDENT?	☐ NO RELATIONSHIP	☐ OTHER
	☐ PARTNER	☐ ACQUAINTANCE
	☐ EX-PARTNER	☐ OTHER, SPECIFY:
	☐ OTHER RELATIVE	
		☐ UNKNOWN
		☐ NOT APPLICABLE

DID DISCRIMINATION⁵ CONTRIBUTE TO THE DEATH? ☐ YES ☐ PROBABLY ☐ NO ☐ UNKNOWN

This checkbox refers to discrimination.
 Discrimination is treating someone less or more favorably based on the group, class or category they belong to resulting from biases, prejudices, and stereotyping. It can manifest as differences in care, clinical communication and shared decision-making. (Smedley et al, 2003 and Dr. Rachel Hardeman)*

Family Interviews often provide insight regarding discrimination determinability.

MMRIA DISCRIMINATION & RACISM FIELDS



Discrimination

Treating someone less or more favorably based on the **group, class or category they belong to** resulting from biases, prejudices, and stereotyping. It can manifest as *differences in care, clinical communication, and shared decision-making*.

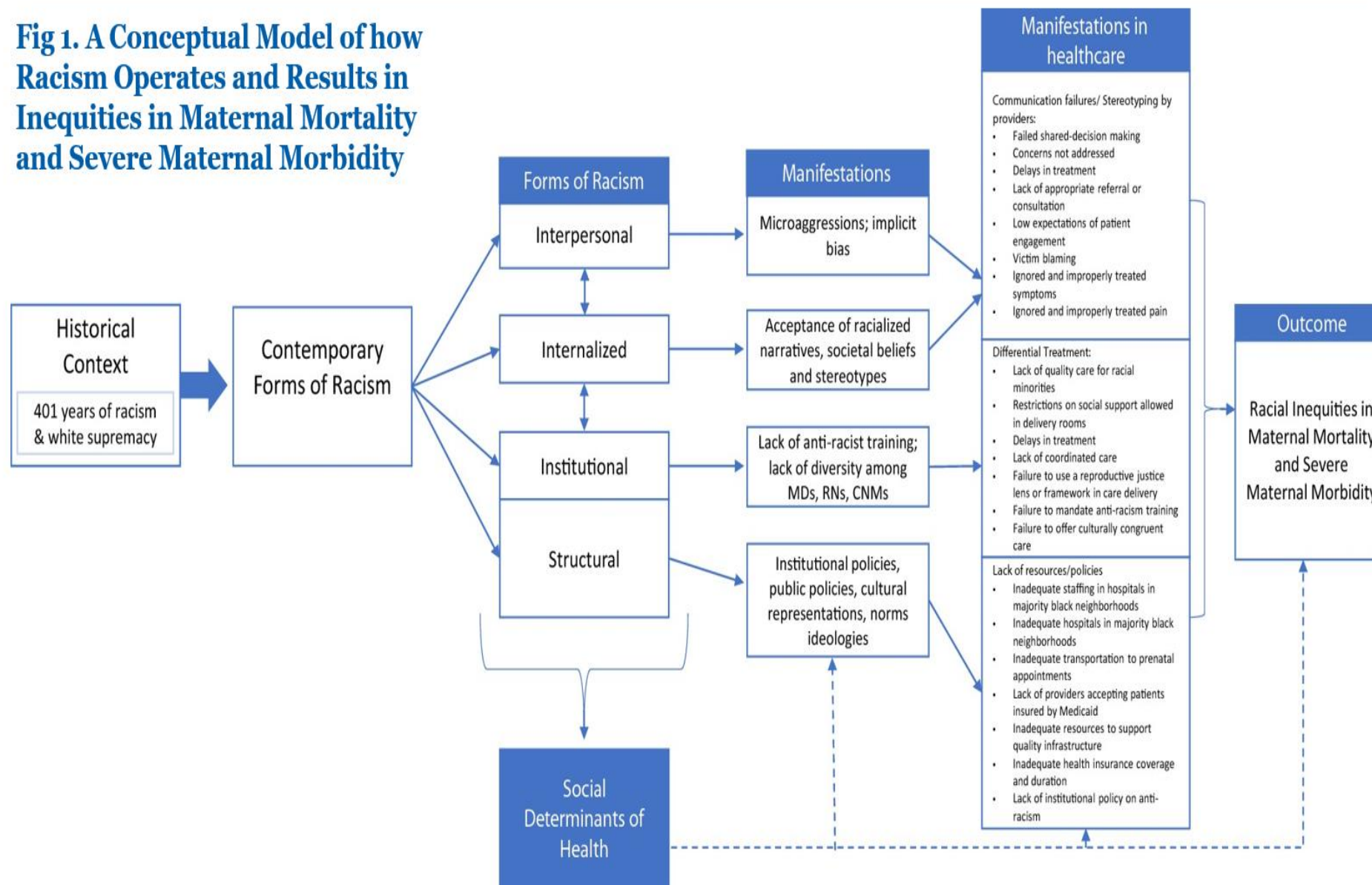
Interpersonal Racism

Discriminatory interaction between individuals based on differential assumptions about the abilities, motives, and intentions of others and resulting in differential actions toward others based on their race. It can be conscious as well as unconscious, and it includes acts of commission and acts of omission. It manifests as *lack of respect, suspicion, devaluation, scapegoating, and dehumanization*.

Structural Racism

Systems of power based on historical injustices and contemporary social factors that systematically disadvantage people of color and advantage white people through inequities in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc.

Fig 1. A Conceptual Model of how Racism Operates and Results in Inequities in Maternal Mortality and Severe Maternal Morbidity





Preventability

COMMITTEE DETERMINATION OF PREVENTABILITY

A death is considered preventable if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors.

WAS THIS DEATH PREVENTABLE?

☐ YES

☐ NO

CHANCE TO ALTER OUTCOME[§]

☐ GOOD CHANCE

☐ NO CHANCE

☐ SOME CHANCE

☐ UNABLE TO DETERMINE

MATERNAL MORTALITY REVIEW COMMITTEE DECISIONS FORM v24 2

COMMITTEE DETERMINATION OF PREVENTABILITY

A death is considered preventable if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors.

WAS THIS DEATH PREVENTABLE? ☐ YES ☐ NO

CHANCE TO ALTER OUTCOME[§] ☐ GOOD CHANCE ☐ SOME CHANCE ☐ NO CHANCE ☐ UNABLE TO DETERMINE

CONTRIBUTING FACTORS AND RECOMMENDATIONS FOR ACTION (Entries may continue to grid on page 3)

CONTRIBUTING FACTORS WORKSHEET

What were the factors that contributed to this death? Multiple contributing factors may be present at each level: Choose one contributing factor per row until all contributing factors have been identified and described.

RECOMMENDATIONS OF THE COMMITTEE

If there was at least some chance that the death could have been averted, what were the specific and feasible actions that, if implemented or altered, might have changed the course of events? Develop one recommendation per row until all contributing factors have been addressed.

DESCRIPTION OF ISSUE (enter a description for EACH contributing factor listed)	CONTRIBUTING FACTOR (enter one per row; repeat as needed if a contributor has more than one recommendation)	LEVEL	COMMITTEE RECOMMENDATION (Who?) should [do what?] (when?) May recommend actions to contributing factors; repeat as needed if a recommendation has more than one contributor.	LEVEL	PREVENTION TYPE (choose below)	EXPECTED IMPACT (choose below)

CONTRIBUTING FACTOR KEY
(DESCRIPTIONS IN APPENDIX B)

- Access/financial - Adherence - Assessment - Chronic disease - Clinical skill/quality of care - Communication - Continuity of care/care coordination - Cultural/religious - Delay - Discrimination - Environmental - Equipment/technology - Interpersonal racism - Knowledge - Law Enforcement - Legal	- Mental health conditions - Outreach - Policies/procedures - Referral - Social support/isolation - Structural racism - Substance use disorder - alcohol, illicit/prescription drugs - Tobacco use - Trauma - Unstable housing - Violence - Other
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DEFINITION OF LEVELS

- PATIENT/FAMILY:** An individual before, during or after a pregnancy, and their family, internal or external to the household, with influence on the individual
- PROVIDER:** An individual with training and expertise who provides care, treatment, and/or advice
- FACILITY:** A physical location where direct care is provided - ranges from small clinics and urgent care centers to hospitals with trauma centers
- SYSTEM:** Interacting entities that support services before, during, or after a pregnancy - ranges from healthcare systems and payors to public services and programs
- COMMUNITY:** A grouping based on a shared sense of place or identity - ranges from physical neighborhoods to a community based on common interests and shared circumstances

PREVENTION TYPE

- PRIMARY:** Prevents the contributing factor before it ever occurs
- SECONDARY:** Reduces the impact of the contributing factor once it has occurred (i.e., treatment)
- TERTIARY:** Reduces the impact or progression of what has become an ongoing contributing factor (i.e., management of complications)

EXPECTED IMPACT

- SMALL:** Education/counseling (community- and/or provider-based health promotion and education activities)
- MEDIUM:** Clinical intervention and coordination of care across continuum of well-woman visits (protocols, prescriptions)
- LARGE:** Long-lasting protective intervention (improve readiness, recognition and response to obstetric emergencies/LARC)
- EXTRA LARGE:** Change in context (promote environments that support healthy living/ensure available and accessible services)
- GIANT:** Address social drivers of health (poverty, inequality, etc.)

Preventability

A death is considered preventable if the committee determines that there was at least some chance of the death being averted by one or more reasonable changes to patient, family, provider, facility, system and/or community factors.

Sourced from: Berg CJ, Harper MA, Atkinson SM, Bell EA, Brown HL, Hage ML, et al. Preventability of pregnancy-related deaths: results of a state-wide review. *Obstet Gynecol* 2005;106:1228–34.

Levels of Prevention



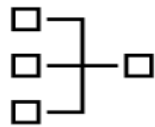
Patient and Family



Provider



Facility



Systems



Community

Contributing Factors



1. Access/financial
2. Adherence
3. Assessment
4. Chronic disease
5. Clinical skill/quality of care
6. Communication
7. Continuity of care/care coordination
8. Cultural/religious
9. Delay
10. Discrimination
11. Environmental
12. Equipment/technology
13. Interpersonal racism
14. Knowledge
15. Law Enforcement
16. Legal
17. Mental health conditions
18. Outreach
19. Policies/procedures
20. Referral
21. Social support/isolation
22. Structural racism
23. Substance use disorder
24. Tobacco use
25. Trauma
26. Unstable housing
27. Violence
28. Other

Specific and Actionable Recommendations

_____ should _____.
 (who?) (do what?) (when?)

WHO is the entity/agency who would have been/be responsible for the intervention?*

WHAT is the intervention and **WHERE** is the intervention point?*

- Patient/Family
- Provider
- Facility
- System
- Community

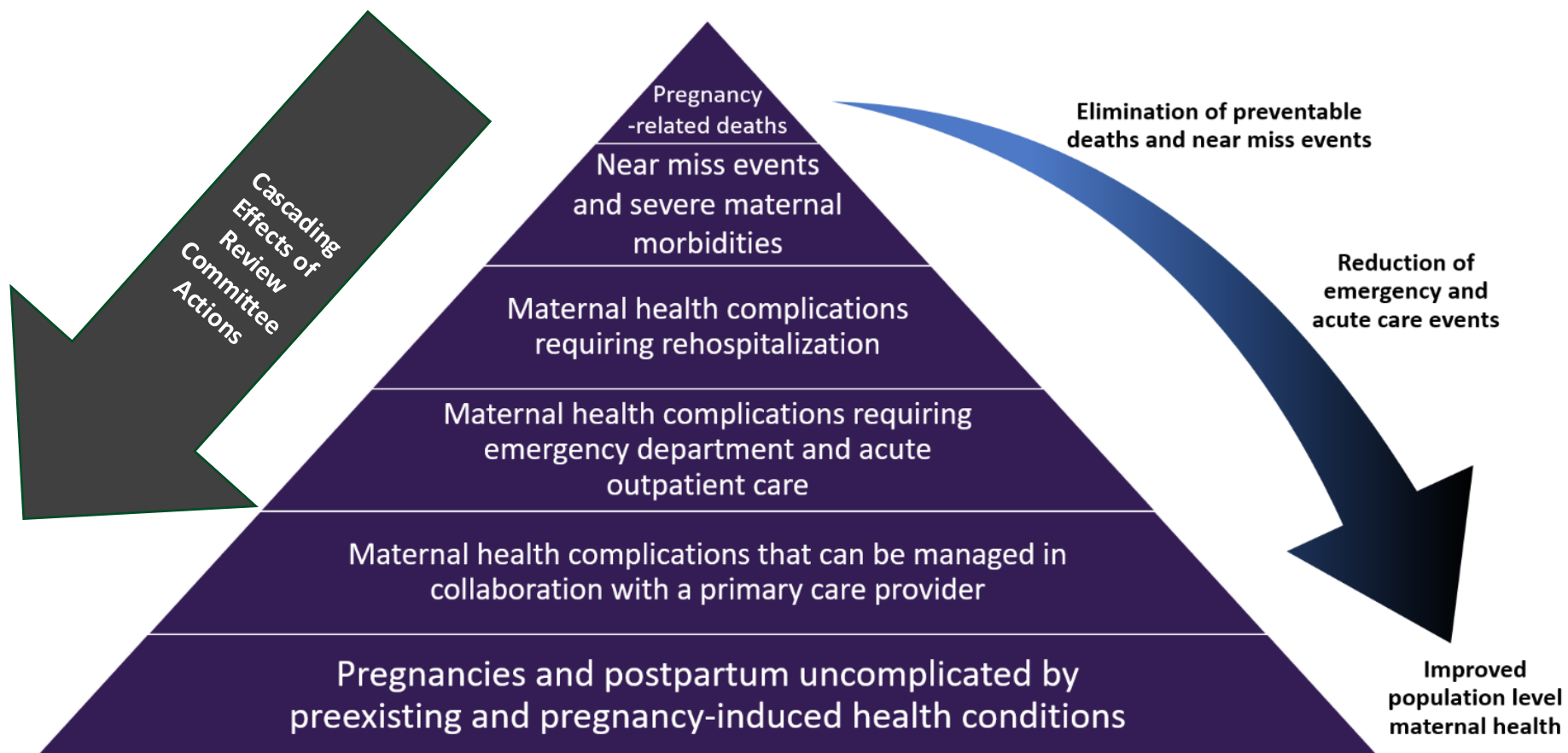
WHEN is the proposed intervention point?

- Among women of reproductive age (“preconception”)
- In pregnancy and in the postpartum period
 - Labor & Delivery (L&D)
 - Prior to L&D hospitalization discharge
 - First 6 weeks postpartum
 - 42-365 days postpartum

*Enter recommendation at the relevant level (Patient/Family, Provider, Facility, System, Community).

Sourced from: MMRIA Facilitation Guide

Data that Fuels Action



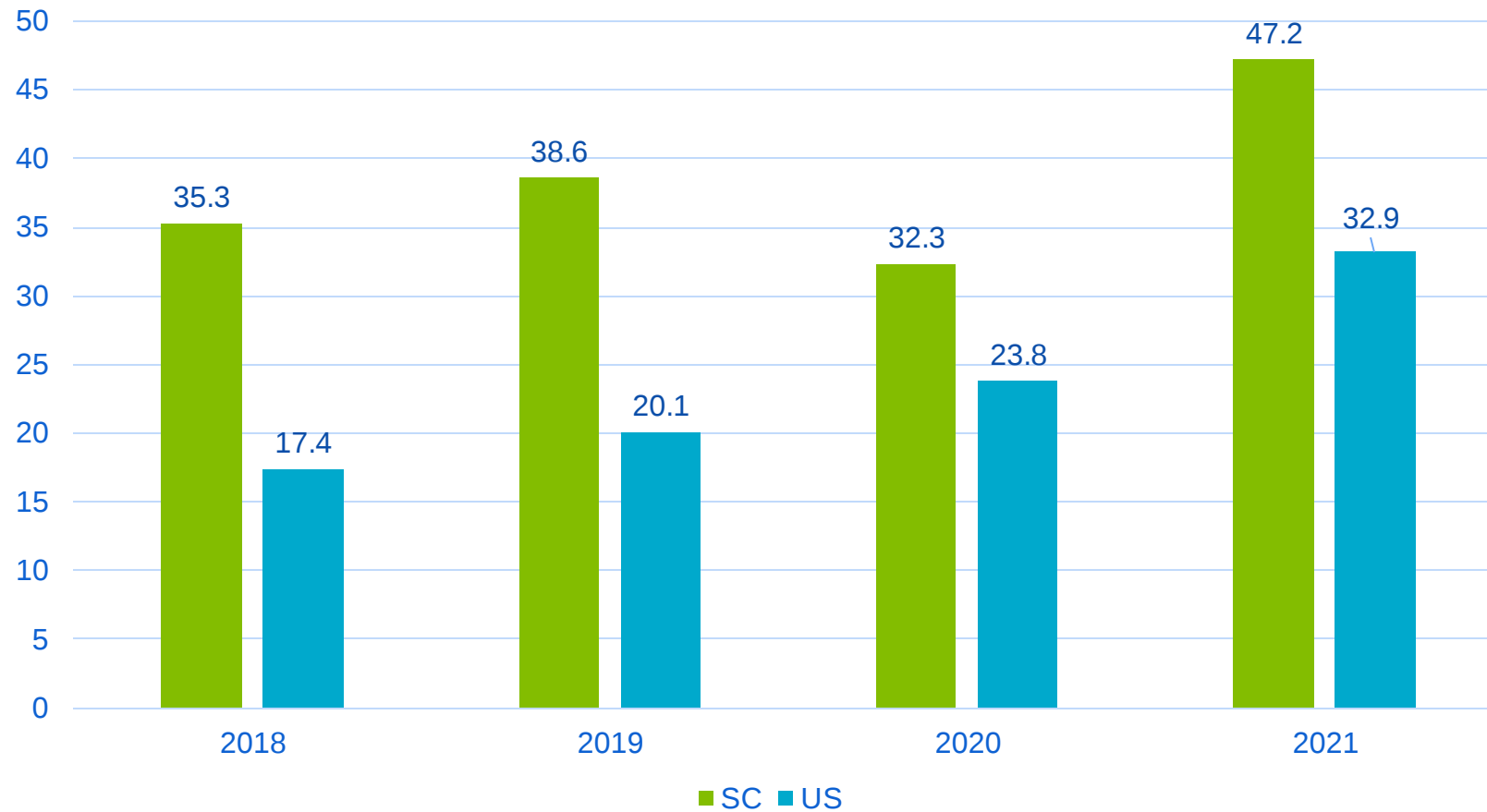
SCMMMRC Data





Pregnancy-Related Mortality Rate, South Carolina and United States

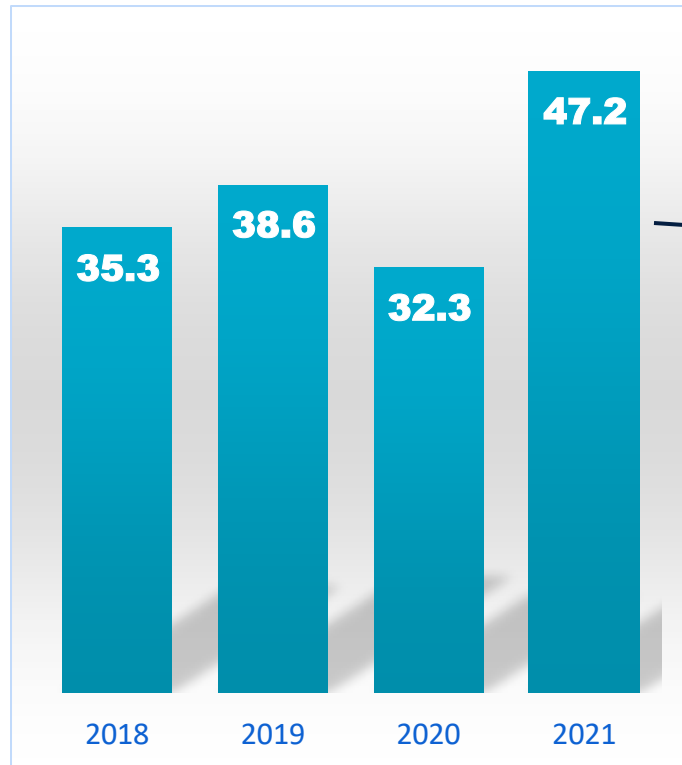
Rate per 100,000 live births





Pregnancy-Related Morality Rate, by Year

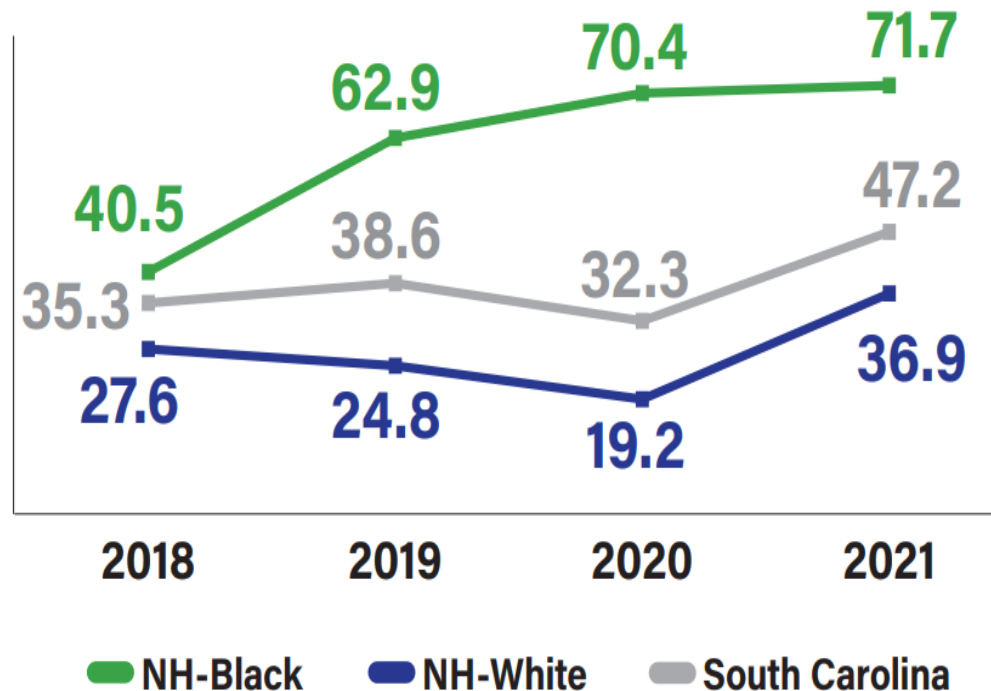
Rate per 100,000 live births



2021 Data Note	
Cases Reviewed	88
Pregnancy-Related Deaths	27
Live Births	57,179
PRMR	27
	57,179
	X 100,000

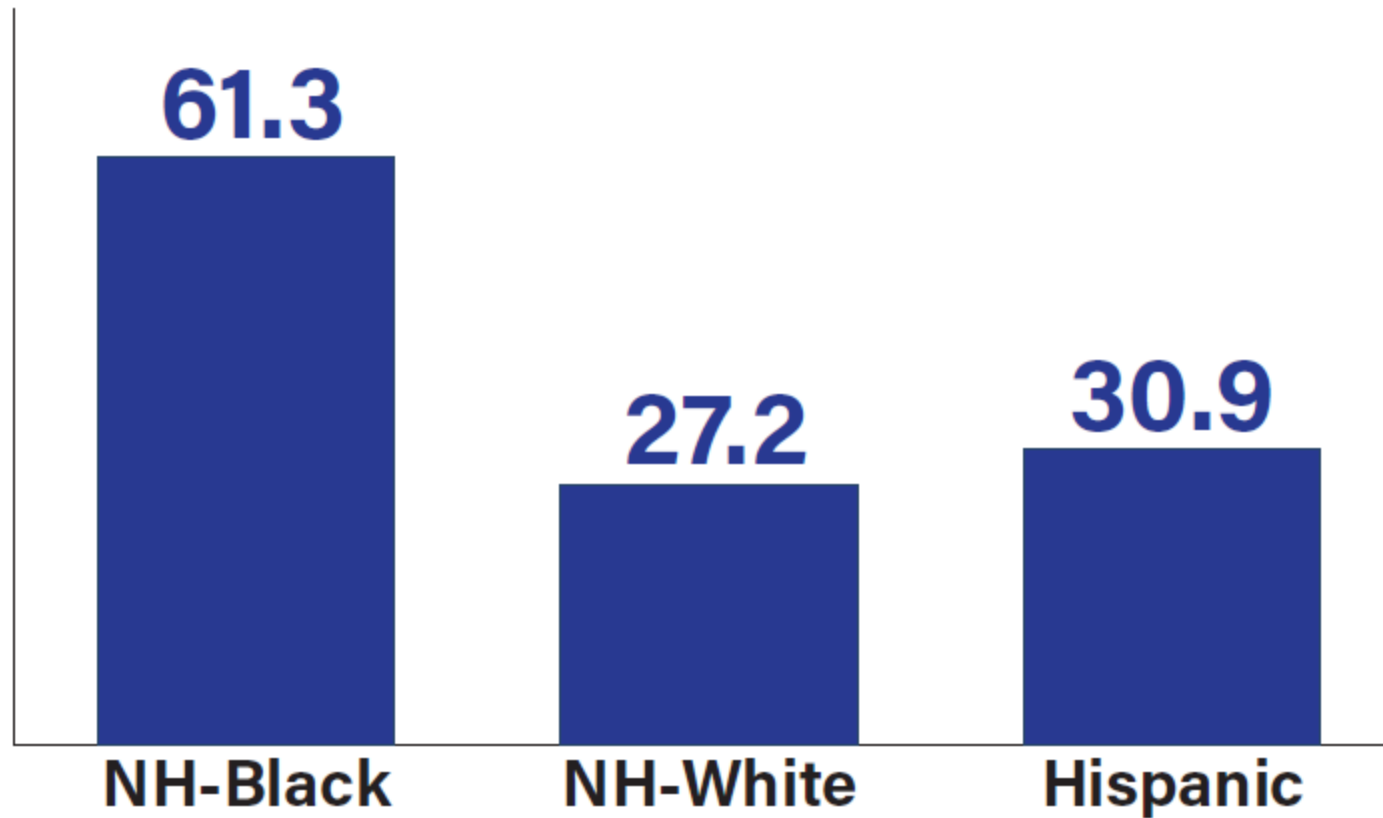
Trend in Pregnancy-Related Mortality Rate, by Race and Ethnicity

Rate per 100,000 live births



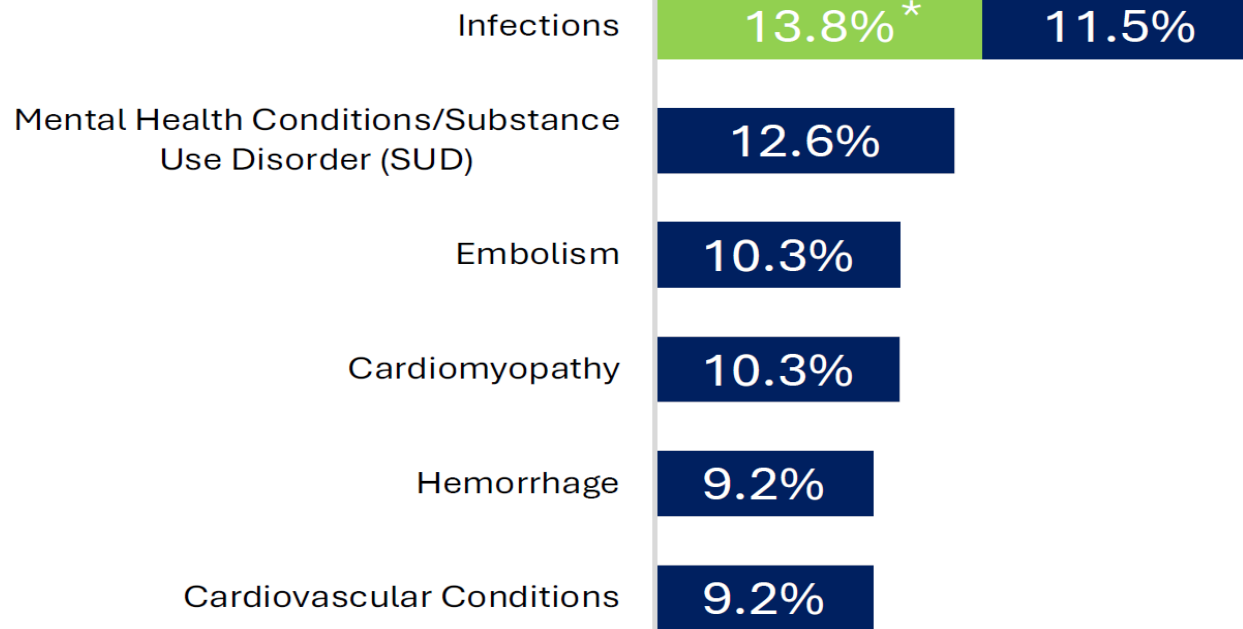
Pregnancy-Related Mortality Rate, Race and Ethnicity, 2018-2021

Rate per 100,000 live births



Leading Causes of Pregnancy-Related Deaths

Percent of pregnancy-related deaths; 2018-2021

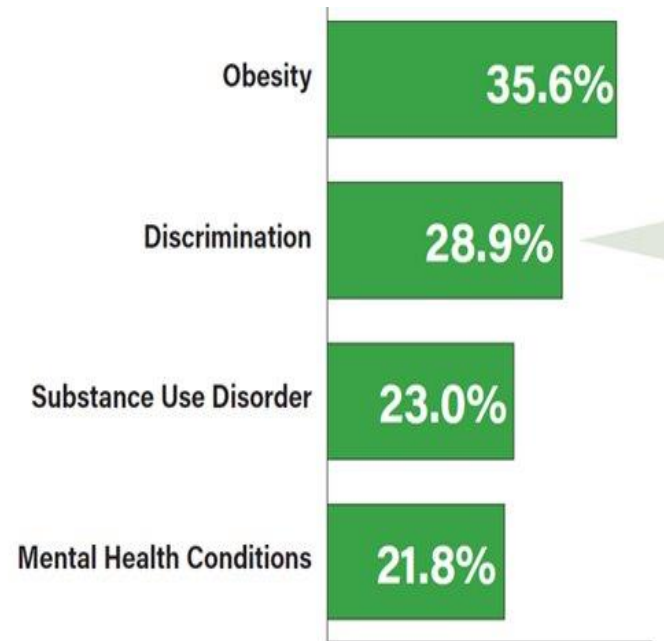


* COVID-19 infections

Non-Hispanic White Women	Non-Hispanic Black Women
• Infections • Mental Health Conditions/SUD • Hemorrhage	• Infections • Embolism • Heart Conditions

Circumstances of Pregnancy-Related Deaths

Percent of pregnancy-related deaths, 2018-2021

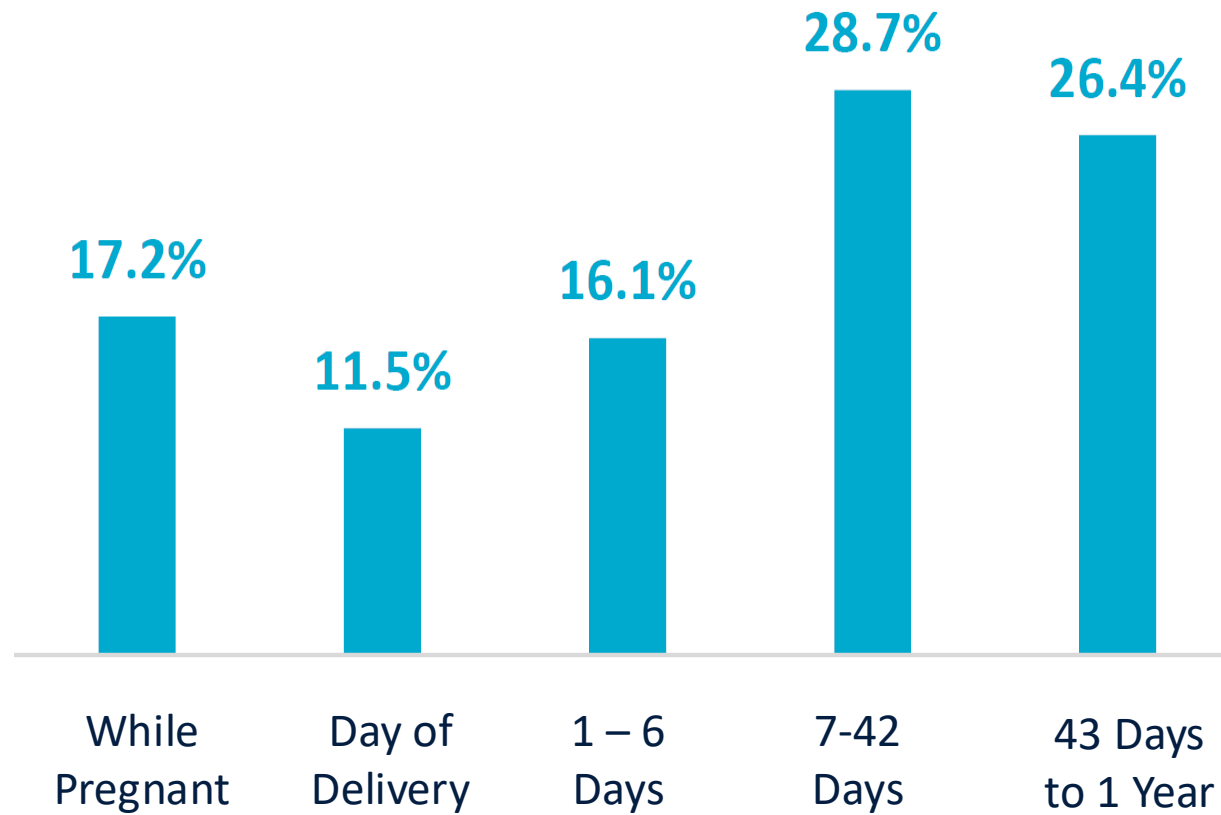


Discrimination

The possibility of discrimination is described as treating someone less or more favorably based on the group, class, or category they belong to resulting from biases, prejudices, and stereotyping. It can manifest as differences in care, clinical communication, and shared decision-making. **Discrimination was recognized as the contributing factor in almost one third of the pregnancy-related deaths reviewed.**

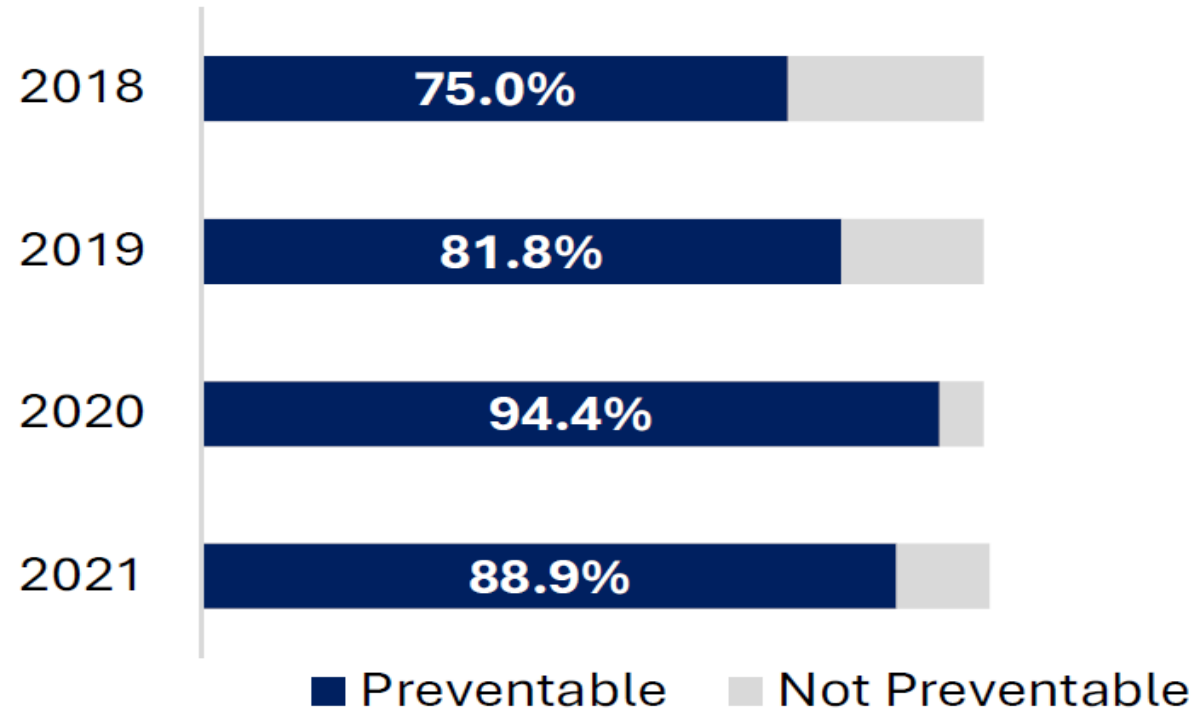
Timing of Pregnancy-Related Deaths

Percent of pregnancy-related deaths; 2018-2021



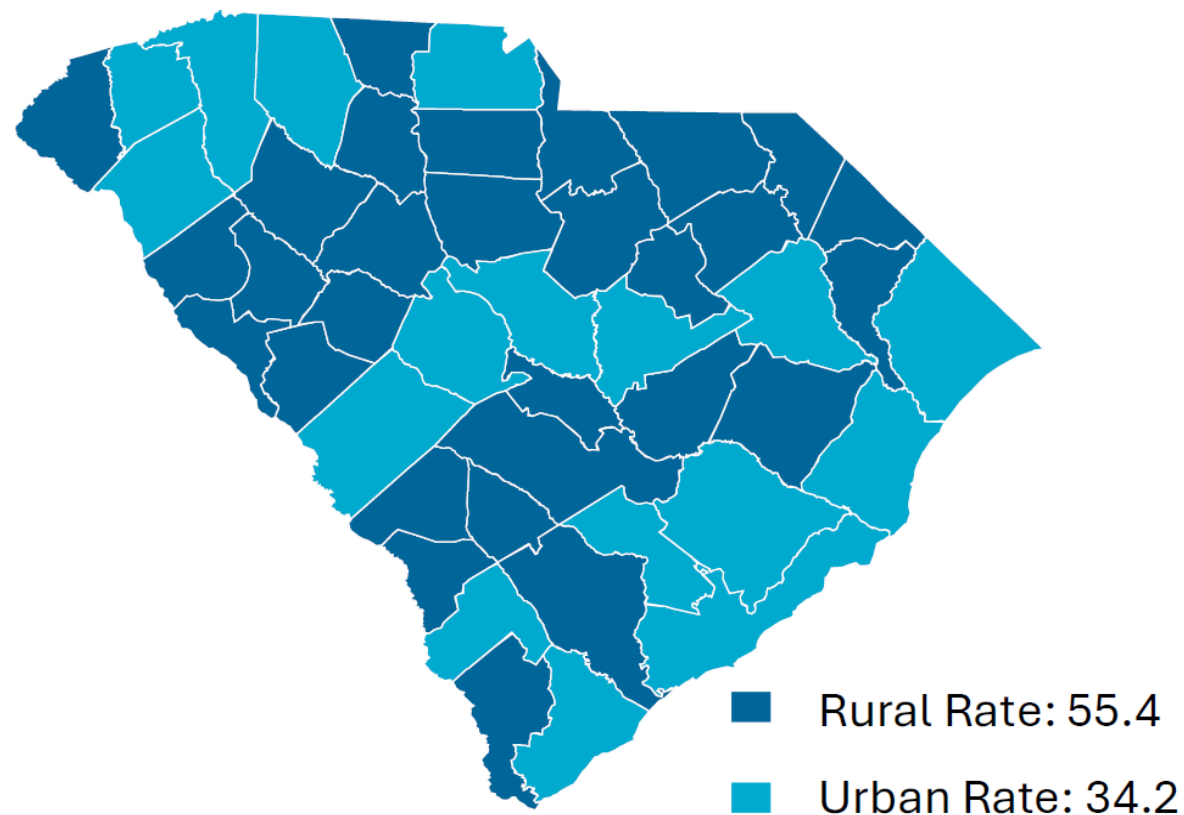
Preventability of Pregnancy-Related Deaths

Percent of pregnancy-related deaths; 2018-2021



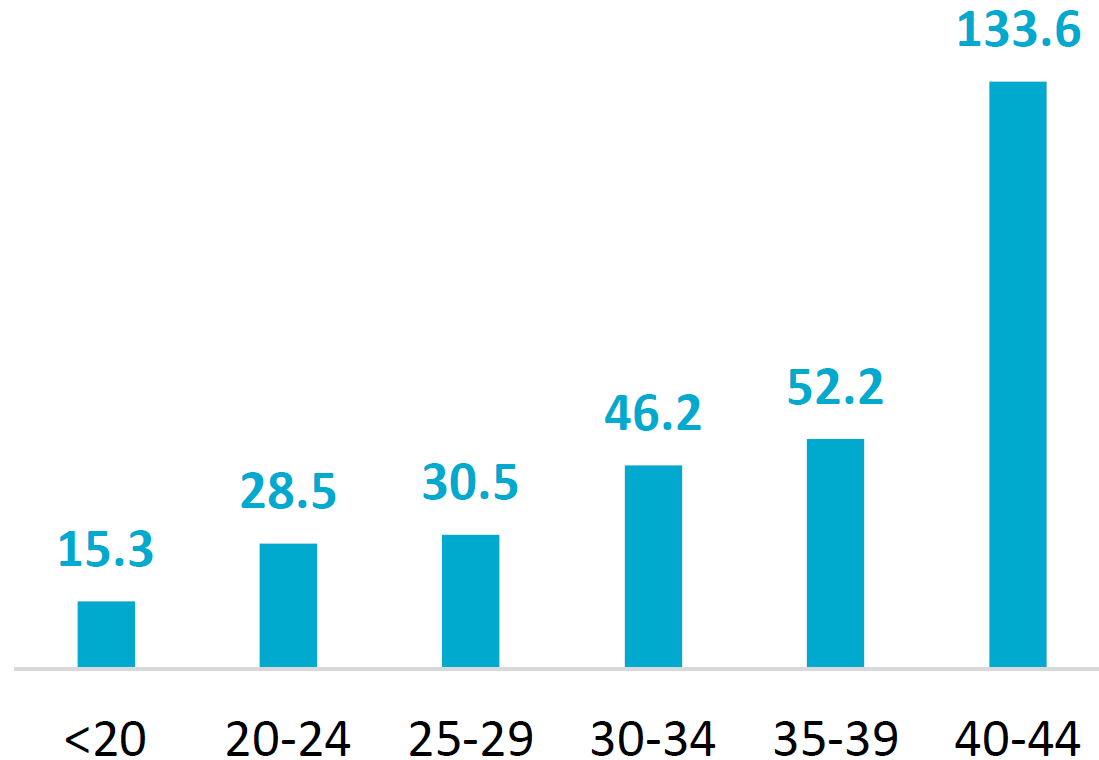
Pregnancy-Related Mortality Rate, by Urban and Rural Designation

Rate per 100,000 live births; 2018-2021



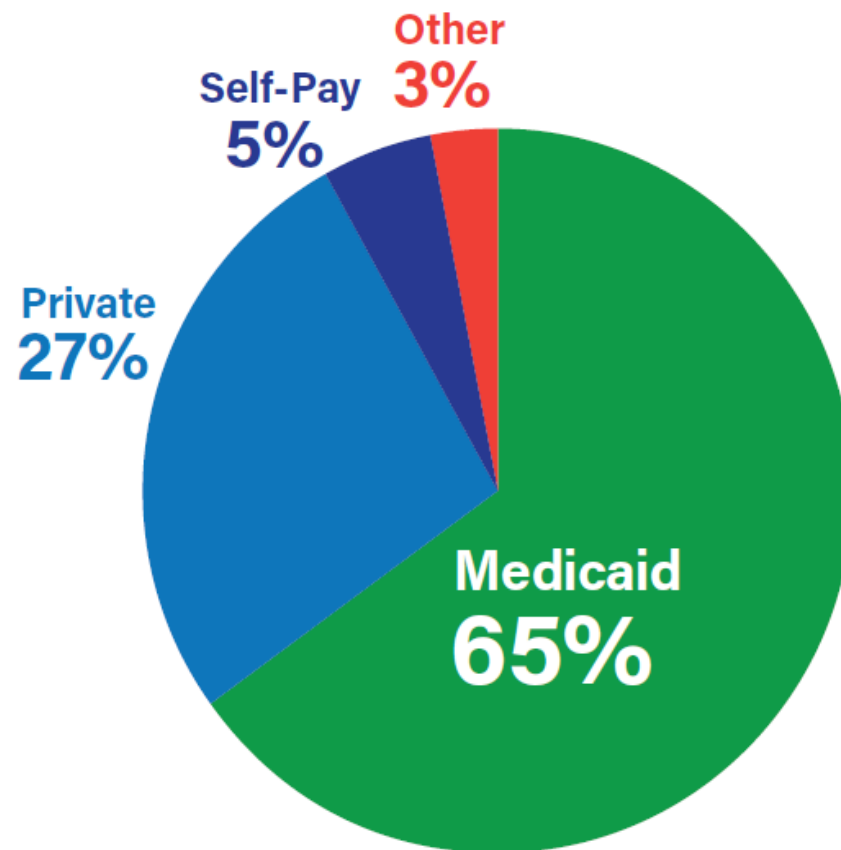
Pregnancy-Related Mortality Rate, by Age

Rate per 100,000 live births, 2018-2021



Pregnancy-Related Deaths, by Payor Source

Percent of pregnancy-related death and live births, 2018-2021





SCMMMRC recommendations to improve maternal outcomes

System Level:

- All women should have **access** to maternity care regardless of where they live and their **ability to pay** for care.
- All pregnant and post-partum women should receive healthcare that is **respectful, non-judgmental, and non-biased** and considers their cultural differences.
- SC should adopt an **access to treatment** model versus a punitive model for pregnant women who have a **substance use disorder**.
- SC should promote **fair treatment** of women with **substance use disorder**; it should be de-stigmatized and given the same consideration as a medical diagnosis.
- **Case management** and **nurse navigators** should be utilized for **care coordination** to assist pregnant women with complex medical conditions, including **mental health conditions** and **substance use disorder**.



Facility Level:

- Facilities should **implement maternal safety bundles** and use these tools to **adopt standards of care**.
- Drug and alcohol **screenings** should be required at facilities for women who received no prenatal care or have a history of **substance use disorder**.
- Additionally, facilities should require Emergency Room physicians and personnel to participate in **training** on the **appropriate care** of pregnant and post-partum women.

Provider Level:

- Providers should **advise** pregnant and post-partum women on the benefits of the COVID-19 and all recommendation vaccines.
- For pregnant women with moderate to severe COVID- 19 infection, providers should **consider the administration** of monoclonal antibodies.
- Providers should **screen** and **refer** pregnant and post-partum women who screen positive for substance use or mental health conditions to the appropriate services for treatment.



Community Level:

- South Carolina communities should provide community **outreach** to include **education** about Urgent Maternal Warning Signs.
- South Carolina should have community-wide **education, resources, and information** about substance use disorder available to pregnant and post partum women and their families.

Patient and Family Level:

- Pregnant women **should follow** of the American College of Obstetricians and Gynecologists and Society for Fetal Medicine recommendations that the Covid-19 vaccination is safe in any trimester.

Thank you! Questions?

Contact Info:

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Kimberly Jenkins jenkinka@dph.sc.gov

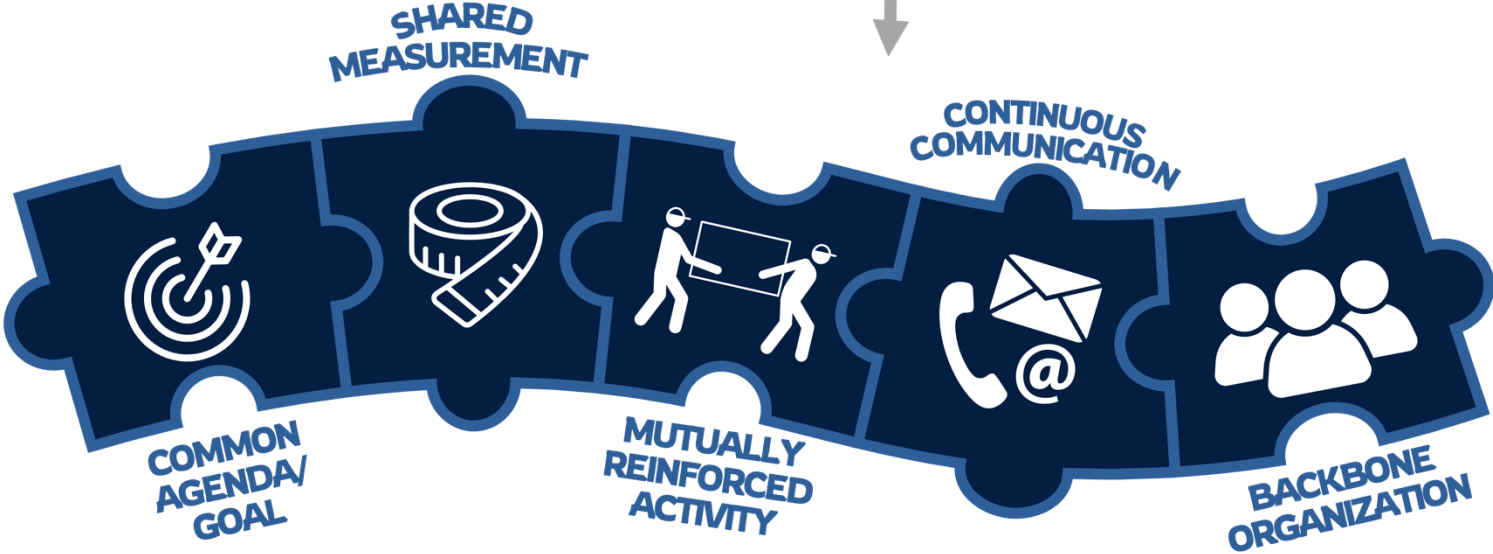


Concurrent Maternal Health Initiatives

**SC DPH Title V
Institute of Medicine & Public Health**



UNITE WITH, INTEGRATE, ALIGN, AND COMPLEMENT THE COMPONENTS OF THESE THREE STATEWIDE INITIATIVES TO IMPROVE MATERNAL AND INFANT OUTCOMES.



COLLECTIVE IMPACT

This framework aims to address complex issues in local communities by aligning multiple organizations and stakeholders around a shared goal to achieve large-scale positive changes.



INCORPORATE THE THREE STATEWIDE PLANS INTO THE WRITING OF THE MCH CHAPTER OF THE SC SHIP.

The collective impact approach aims to foster collaboration, minimize duplication of efforts, prevent partner burnout, complement current efforts, and eliminate contradicting elements.

MATERNAL & INFANT STATEWIDE HEALTH IMPROVEMENT INITIATIVES		 CYCLE	 POPULATION DOMAINS	 AIM	 FIRST MEETING	 IMPLEMENTATION	MEETING SCHEDULE
	 Health Resources & Services Administration MATERNAL HEALTH INNOVATION GRANT	5 YEARS	Maternal	Impact and reduce infant and maternal mortality and morbidity.	AUG 2024	AUG 2024	Aug 2024 Dec 2024 Mar 2025 Jun 2025 Sep 2025
	 South Carolina Institute of Medicine & Public Health MATERNAL AND INFANT PROJECT	10* YEARS	Infant & Maternal	Impact and reduce infant and maternal mortality and morbidity with focus on access to care.	AUG 2024	MAY 2025	Aug 2024 Sep 2024 Oct 2024 Nov 2024 Dec 2024 Jan 2025 Feb 2025 Mar 2025
	 SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH MCH TITLE V NEEDS ASSESSMENT	5 YEARS	Infant Maternal Children Adolescent & CYSHCN	Impact overall health throughout all five domains.	SEP 2024	JUL 2025	Sep 2024 Jan 2025 Apr 2025 Jun 2025
SHIP: STATE HEALTH IMPROVEMENT PLAN MATERNAL/INFANT		CYCLE 5 YEARS	POPULATION DOMAINS Infant & Maternal	AIM Impact and reduce infant and maternal mortality.	FIRST MEETING JAN 2024	IMPLEMENTATION JAN 2025	

*Includes 1-, 3-, and 10- year milestone and action items.

Panel Discussion

Community Birth Workers in Clinical Settings



Panel Discussion: Community Birth Workers in Clinical Settings

- This panel will explore the evolving role of community-based maternal health workers, examine barriers to integration, and discuss strategies to foster stronger partnerships between clinical and community providers.



Participants

Jeffery Hall, MD

Clinical Professor of Family & Preventive Medicine
University of South Carolina

Keisha Lockhart, DNP, CMN

Primary Care Pediatric Nurse Practitioner and Nurse Midwife,
Founder & Owner
AfterBirth, LLC

Sara Covington-Kolb, CCHW, MSPH, MSW

Program Impact Manager
Center for Community Health Alignment

Symon'e Johnson

Certified Holistic Doula, Founder & Owner
Pamoja Partnership

Rho Sims

Community Organizer
Black Maternal Health Collective & Preeclampsia Foundation

Stormi Harmon

Certified Holistic Doula & Doula Trainer, Founder & Owner
Set Apart Collective



Panel Discussion

Community Birth Workers in Clinical Settings



Partners in Innovation

An Overview of Projects Supported by MHI



MHI Supported Projects



SCMMMRC Nurse Abstractors



South Carolina State University

Mommy's Café
Unite South Carolina



Project ECHO



MHI Supported Projects



SIMCoach

Expansion to emergency departments and non-birthing hospitals



Prisma Health Clinical Consultant

Low fidelity, simulation-based curriculum
Virtual training opportunities for rural providers



USC MCH Catalyst Student Internships



University of South Carolina's Institute for Families in Society (IFS)



Maternal Health Resource Hub

AI Chat Box Integration

Localized Data

Empowerment & Literacy



USC College of Engineering and Computing



Alliance for Innovation Community Care Initiative (AIM CCI)



Institute for Families in Society



SIMCoach Evaluation



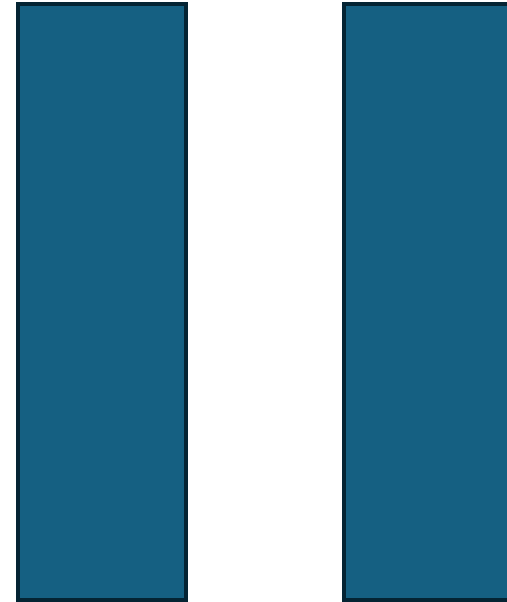
USC Patient Engagement Studio Perinatal Advisory Council



Small Grants Program



Break



Chat Question

If you could instantly master one skill, what would it be and why?



Breakout Sessions: Workgroups



Data Collection,
Analysis, & Distribution



Service Delivery



Workforce
Development



Empowerment &
Literacy



Next Steps

- Post Meeting Survey
- Next Meetings
 - Workgroups
 - May 2025
 - MHTF
 - June 17, 2025



<https://redcap.link/scmhic3>





THANK YOU!



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